HEALTH CARE PARTNERS OF SC, INC.

843-248-4700 Fax: 877-322-0181

Patient Registration Chart #_____

Patient Name: _____
LAST NAME FIRST NAME MIDDLE INITIAL

SS #: _____ **DOB:** _____ **Age:** _____ **Sex:** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Email Address:** _____

☐ ***Register for Patient Portal***

Preferred Pharmacy

☐ **HCPSC Pharmacy Conway** ☐ **HCPSC Pharmacy Marion** ☐ **HCPSC Pharmacy Johnsonville**

☐ **Other:** _____ **Address:** _____ **Phone Number:** _____

Responsible Party: ☐ **Self** ☐ **If under the age of 18, please provide parent-guardian name(s)** _____

DOB: _____ **Phone #:** _____ **Email address:** _____

Emergency Contact 1: _____ **Relation to patient:** _____ **Phone #:** _____

Do we have permission to share medical/psychiatric information with the emergency contact? ☐ **Yes** ☐ **No**

Emergency Contact 2: _____ **Relation to patient:** _____ **Phone #:** _____

Do we have permission to share medical/psychiatric information with the emergency contact? ☐ **Yes** ☐ **No**

Communication Method: ☐ **Call Home** ☐ **Call Cell** ☐ **Call Work** ☐ **Text Message** ☐ **Patient Portal**

Type of Reminders: Notifications ☐ **Appointments** ☐ **Lab Results** ☐ **Health Reminders** ☐ **Medication** ☐ **General**

Preferred Time to Call/Text: ☐ **Morning** ☐ **Afternoon** ☐ **Evening**

Can we leave detailed personal health information on your voice message? ☐ **Yes** ☐ **No** ☐ **Home** ☐ **Cell**

If you have insurance of any kind, please present your card(s) at the front desk for billing and lab purposes.

Primary Insurance: _____ **Insured's Name:** _____

Policy #: _____ **Group #:** _____ **Patient relationship to Insured:** _____ **DOB:** _____

Employer Name: _____ **Employer Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Secondary Insurance: _____ **Insured's Name:** _____

Member ID: _____ **Group #:** _____ **Patient relationship to Insured:** _____ **DOB:** _____

Housing: ☐ Homeowner or Renter ☐ Public Housing ☐ Homeless ☐ Other: _____

If Homeless: ☐ Homeless shelter ☐ Doubling Up ☐ Transitional ☐ Street ☐ Other

In the past 2 years, have you or a member of your family worked in agriculture on a seasonal basis? ☐ Yes ☐ No

Have you or your family established a temporary home to work in agriculture? ☐ Yes ☐ No

Have you ever served in the US military? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Legally Separated ☐ Divorced ☐ Widowed

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____ **Translator Required?** ☐ Yes ☐ No

Race: ☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ More than One Race

☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian

☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan

Ethnicity: ☐ Not Hispanic, Latino/a, or Spanish Origin ☐ Mexican, Mexican American, Chicano/a

☐ Cuban ☐ Puerto Rican ☐ Other Hispanic, Latino/a, or Spanish Origin ☐ Choose Not To disclose

Employment Status: ☐ Full time ☐ Part-time ☐ Self Employed ☐ Retired ☐ Active-Duty Military ☐ Not Employed

Student Status: ☐ Full time ☐ Part-time ☐ Not A Student

Please note: Payment is required at the time of service for all copayments, deductibles, and coinsurance, as dictated by your insurance company or sliding scale schedule. If needed, please make payment arrangement prior to your visit.

I understand that my medical information is confidential, but I authorize its release to my insurance companies, or as required by law.

Patient/Guardian Signature: _____ **Date:**_____

How Did You Hear About Us? ☐ Billboard ☐ Community Event ☐ Family/Friend ☐ Radio/TV

☐ Online/Social Media ☐ Other: _____

Family Size (# of people in household): _____ **Currently on Sliding fee:** ☐ Yes ☐ No

Amount of income received: **Weekly:** _____ **Monthly:** _____ **Annually:** _____

FOR OFFICE USE ONLY

Staff Name: _____

Please print

Revised 02/13/2025